New Jersey Department of Health and Senior Services
PO Box 364, Trenton, NJ 08625-0364

CHILD HEALTH RECORD

Patient Name (Last, First, MI)

Date of Birth | Sex

Name and Address of Backup Health Care Provider

PERMISSION FOR EXAMINATIONS, IMMUNIZATIONS AND TESTS:
I hereby request that my child be given the examinations, immunizations, and tests recommended by the health care provider.

(Signature)

(Date) (Relationship)

County _____ Municipality _____

Child Health Conference (address) _____

Father _____ Occupation _____

Mother _____ Occupation _____

Address* _____

Telephone* _____

**Use pencil for eventual changes.*

FAMILY HEALTH (NOTE CHRONIC ILLNESS, MENTAL ILLNESS, ALLERGIES, ETC., OR CAUSE OF DEATH)

Relation	Year of Birth	State of Health
Father		
Mother		
Brother/Sisters		

Has any relation had:	No	Yes	Relation
Significant allergy	☐	☐	
Rheumatic fever	☐	☐	
Heart disease	☐	☐	
Diabetes	☐	☐	
Tuberculosis	☐	☐	
Convulsive disorder	☐	☐	
Mental illness	☐	☐	
Cancer	☐	☐	

Additional Information: _____

IMMUNIZATIONS*

DTP or DTaP	1	2	3	
	4	5		
Td	1	2	3	
Polio	1	2	3	
	4			
Hib (Specify type)	1	2	3	
	4			
MMR	1	2		
Measles				
Rubella				
Mumps				
Hepatitis B	1	2	3	
HBIG				
Varicella (Specify):	☐ Disease ☐ Vaccine	1	2	
Pneumococcal Conjugate (PCV 7)	1	2	3	
	4			
Pneumococcal				
Influenza	1a	1b	2	3
Hepatitis B Serology	Date:	Titer:		
Varicella Serology	Date:	Titer:		

**Transfer information from the immunization record onto this form. Attaching the immunization record is not acceptable. A printout from the immunization registry is acceptable. Note that ages 11-14 only requires two doses of Hepatitis B. Note whether date for Varicella is from disease (month/year) or vaccine (month/day/year). Note reactions by circling injection date in red. Also make entry in progress notes. Nurse to chart site and initial.*

TUBERCULIN TESTS

Date	Type/Lot No.	Reaction (mm Induration)

SCREENING

Type	Hearing*			Vision			Developmental (i.e., DDST)						Speech	
Date														
Type of Test														
Result														

**Note date if SCH-2 received (6 months hearing screening):*

LAB SCREENING TESTS (IF DONE)

Type	Date	Result	Date	Result	Type	Date	Type	Result
Hct/Hgb					**Lead**			
Hct/Hgb					**Lead**			
IEM					**Lead**			
Other					**Lead**			

PERSONAL HEALTH HISTORY

BIRTH HISTORY

	NO	YES
Illness of mother during pregnancy:	☐	☐
Unusual labor or delivery:	☐	☐

Type of Delivery: _____

Birth weight: _____

Apgar score: _____

Neonatal Condition: _____

Length of Hospital Stay: _____

Name of Hospital: _____

Any difficulties in first days of live: ☐ ☐

DETAILS AND ADDITIONAL INFORMATION:

_____

_____

_____

DEVELOPMENTAL RECORD

Keep current. Note age in months. (Figure in parentheses indicates age in months by which 90 percent of children reach this stage.)

Smiles responsively: _____ (2)

Eyes follow moving object past midline: _____ (2-1/2)

Head steady when sitting: _____ (4-1/2)

Sits without support: _____ (8)

Plays peek-a-boo: _____ (10)

Plays pat-a-cake: _____ (13)

Says single meaningful word: _____ (13)

Walks without support: _____ (14)

Drinks from cup: _____ (17)

Says a few words: _____ (20)

Pedals tricycle: _____ (36)

Plays interactive games: _____ (42)

PHYSICAL EXAMINATIONS

Record details of examinations, interval history, immunization reactions, physician's recommendations, and other pertinent data in progress notes. Reasons for and dates of referrals to other agencies should be recorded.

Coding: ✓ - No abnormality noted
P – See Progress Notes
R – Recommendation/Referral/Rx

Date												
Age												
Weight												
Height												
Head Circumference												
Chest Circumference												
B/P (Over 3 Years)												
Temperature												
General Appearance												
Development												
Skin												
Skeletal and Extremities												
Head and Neck												
Mouth												
Teeth												
Throat												
Ears												
Eyes												
Heart												
Lungs												
Abdomen												
Hernia, Genitals												
Vocalization/Speech												
Hearing												
Reflexes												
Behavior												
Examiner's Signature (Initials)												

PROGRESS NOTES

(Use red ink to note allergies, significant illnesses, injuries, hospitalizations and surgeries.)

(Progress Notes section continues on back page.)

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)

CONSENT TO PARTICIPATE

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my child's immunizations are due and to keep a central record of my child's immunization history. I understand that I can get a copy of my child's record from my medical provider or local health department.

There is no cost to participate in this program.

- ☐ Yes, I would like to participate in this program.
- ☐ No, I do not want to participate in this program.
- ☐ Yes, I am already a participant, NJ Registry # _____

Signature of Parent/Guardian	Date

PROGRESS NOTES

(Use red ink to note allergies, significant illnesses, injuries, hospitalizations and surgeries.)